RESEARCH PAPER

Comparison of Health Insurance Coverage for Hearing Aids and Other Services in Alberta

Comparaison de la couverture de l'assurance maladie pour l'aide auditive et d'autres services en Alberta

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Abstract

Objectives: Of the several barriers associated with uptake and adherence to hearing services, cost is the most commonly identified barrier in Canada. This study evaluated health insurance plans for hearing care coverage within Alberta, Canada, and subsequent out-of-pocket expenses that would result if an individual chose to pursue treatment.

Methods: An investigation of eight companies that provide supplementary health coverage in Alberta was conducted. Categories of health service coverage included hearing, vision, speech-language pathology (S-LP), physical therapy related (PT-R; including massage therapy and chiropractic therapy) and alternative medicine related (AM-R; including osteopathy, acupuncture and naturopathy). All coverage amounts were corrected to a four-year term for comparison purposes.
Results: For a four-year term, the coverage amounts for hearing services were CAD 300–750; for vision services were CAD 0–900; for S-LP services were CAD 0–2,400; for PT-R services were CAD 1,400–10,200; and for AM-R services were CAD 0–10,200 per four-year term. The expected out-of-pocket expense for vision ranged from CAD 0 to CAD 2,766, whereas for hearing, it ranged from CAD 250 to CAD 11,700.
Conclusion: A considerable range and discrepancy were reported between hearing care and most paramedical services. In addition, the coverage amounts for hearing care were inconsistent with treatment costs, resulting in considerable out-of-pocket expenses for most consumers. The potential implications of such cost-related barriers on public health are an important consideration as our understanding of the impact of untreated hearing impairment continues to increase.

Résumé

Objectifs : Parmi les multiples obstacles qui touchent le recours aux services d'aide à l'audition, le coût est le facteur le plus souvent mentionné au Canada. Cette étude évalue les régimes d'assurance pour les services d'audiologie en Alberta (Canada) et les dépenses personnelles subséquentes si un patient choisit de suivre un traitement.
Méthode : Nous avons mené une enquête auprès de huit compagnies qui offrent une protection supplémentaire en matière de santé en Alberta. Les catégories couvertes comprennent : l'audiologie, les soins de la vue, l'orthophonie, la physiothérapie (incluant les massages thérapeutiques et la chiropratique) et la médecine alternative (incluant l'ostéopathie, l'acupuncture et la naturopathie). Aux fins de la comparaison, les montants de la couverture ont été corrigés sur une période de 4 ans.
Résultats : Pour la période de 4 ans, les montants de la couverture pour les services d'audiologie étaient de 300 à 750 $ CA; pour les services de soins de la vue, de 0 à 900 $ CA; pour les services d'orthophonie, de 0 à 2 400 $ CA; pour les services de physiothérapie, de 1 400 à 10 200 $ CA; pour la médecine alternative, de 0 à 10 200 $ CA. Les dépenses personnelles estimées pour les soins de la vue étaient de 0 à 2 766 $ CA, tandis qu'ils allaient de 250 à 11 700 $ CA pour l'audiologie.
Conclusion : Il y d'importantes divergences entre les services d'audiologie et la plupart des services paramédicaux. De plus, le montant de la couverture pour les services d'audiologie était incompatible avec le coût des traitements, entraînant des dépenses personnelles considérables pour la plupart des consommateurs. Les répercussions potentielles liées aux obstacles

financiers en matière de santé publique méritent notre attention, notamment avec l'apport continu de nouvelles connaissances sur l'impact des déficiences auditives non traitées.

Introduction

In spite of the steady advances in technology, uptake and adherence to hearing aids remain surprisingly low. Estimates put the proportion of Canadian adults using a hearing aid who could benefit from one at approximately 20% (SAC Hearing Aids Infographic 2018). The public health implications of untreated hearing impairments has become a topic of much discussion (Deal et al. 2017; Lin and Albert 2014; Livingston et al. 2017), in turn leading to additional inquiries into the uptake of hearing aid services. The reasons for poor uptake, commonly defined as barriers, have been extensively studied and found to be complex and multifactorial (Knudsen et al. 2010). Many of these barriers, such as inherent personality traits and attitudes, can be challenging to quantify and cannot be easily modified. However, the influence of some external factors, particularly cost, is easier to measure and potentially change (i.e., by way of decreasing cost or increasing insurance coverage).

Cost is consistently identified as one of the most common reasons individuals do not obtain treatment for hearing loss (Abrams and Kihm 2015; Knudsen et al. 2010; O'Rourke 2014). And, although removal of cost entirely (i.e., Scandinavian countries where hearing care is completely covered) does not lead to a drastic change in uptake and adherence of hearing services, cost is the most commonly reported barrier (whether perceived or real) in Canada and, thus, is a patient-oriented concern that requires better understanding. The retail range for hearing aids reported in the literature and news media is sizable, from a few hundred to upwards of $10,000 (Grundfast and Liu 2017; O'Rourke 2014). Investigators from the Canadian Broadcasting Corporation's Marketplace, a seasoned consumer watchdog program, reported difficulty obtaining details about hearing aid prices and costing ("Hearing Aids: Our Insider's Take" 2013). It is not surprising then that the purchasing process is challenging and intimidating for a novice consumer with a communication impairment. This confusion over what constitutes a fair price, along with individual financial constraints, possibly leads to avoidance, which likely contributes to low adoption rates.

To remove cost as a barrier, an individual must be able to receive treatment with zero or very minimal out-of-pocket expenses. However, with Canadians having access to both public and private health insurance plans that vary significantly from province to province, it can be difficult for individuals to understand how to minimize their costs. Furthermore, hearing care, including funding, programs and services, falls outside of the mandate of the *Canada Health Act* (O'Rourke 2014). Under the Act, provincial and territorial health plans are only required to provide insured residents (i.e., those with a valid health card) with "reasonable access to medically necessary hospital and physician services" (Canada Health Act Division 2011). This broad definition allows for different interpretations between provinces.

Currently, the gaps in publicly funded coverage, be these provincial, territorial or federal programs (e.g., Veteran Affairs Canada), must be filled out of pocket by the consumer or

by extended health insurance plans. Before any recommendations can be made with respect to modifications of insurance coverage for hearing treatment, or before information can be provided to individuals seeking coverage for hearing impairment, a comprehensive review of insurance plans needs to be documented to describe the current gaps in coverage.

The objective of this study was to evaluate private, supplementary, and non-group health insurance plans for hearing care coverage within Alberta, Canada, and to compare the coverage amounts with other paramedical health services. A second objective was to provide a description of the coverage range and subsequent out-of-pocket expenses that would result if an individual chose to pursue treatment for hearing loss with and without insurance coverage.

Methods

An investigation of insurance companies that provide supplementary health coverage in Alberta was conducted using publicly available data found through Internet searches done in April and May of 2018. Eight companies were identified and considered (labelled A through H in Table 1, available online at longwoods.com/content/26070). The included companies had an online presence and plan information that could be accessed online or over the phone. Supplementary health coverage is insurance provided by insurers to reimburse expenses not covered by government plans (e.g., prescription drugs and dental services).

The plans evaluated were non-group benefits available to adult Canadians (i.e., 18–64 years of age inclusive) with minimal restrictions for enrolment. In Alberta, most individuals under 18 and over 64 years of age qualify for hearing benefits through the Alberta Government program Alberta Aids to Daily Living. These benefits include new amplification purchases (e.g., hearing aids and personal listening devices) and repairs. And although the full details of this program are beyond the scope of this study, its availability to Alberta residents is the reason this investigation focused on the age group (i.e., 18–64 years of age inclusive) that typically cannot access these resources unless they are below a defined low-income level (Alberta Health 2018). Group plans were also not reported, as these are only available to a select portion of individuals (e.g., employer-sponsored health plan for eligible employees). Other provincial, territorial or federal programs (e.g., Veterans Affairs Canada, Workers' Compensation Board and social-based programs) were also not included, as enrolment numbers and coverage amounts were not publicly available.

Categories of health service coverage were defined as hearing, vision, speech-language pathology (S-LP), physical therapy related (PT-R) (including physiotherapy, massage therapy and chiropractic therapy) and alternative medicine related (AM-R) (including osteopathy, acupuncture and naturopathy). Minimum and maximum coverage amounts were determined for each company, as supplementary health plans often contain several levels of coverage choices (e.g., basic vs. upgraded).

All coverage amounts were corrected to a four-year term for comparison purposes. Five companies offered hearing service coverage every four-year benefit period, and three companies had a five-year benefit period for hearing services. This contrasts with the one-year benefit period for the other categories of coverage, excluding vision. Seven companies offered a two-year benefit period for vision services, and one company offered a three-year term. The term correction was achieved by dividing the coverage amount by the benefit period and then multiplying this amount by four. For example, a company that offered CAD 500 every five-year benefit period was corrected to CAD 400 (i.e., CAD 500/5-year benefit period × 4-year benefit period).

Minimum and maximum customer monthly plan costs (i.e., the range consumers would pay for coverage; higher costs equated to more coverage) were also recorded for each company. This information was readily available on most company websites. Those companies that required limited information (i.e., age and sex) about the applicant before releasing a quote or plan rates were provided with profiles of a 30-year-old man and 60-year-old woman who resided in Edmonton. Numerous factors contribute to a company's proprietary calculation of monthly plan rates. However, if health insurance costs were to vary by age and sex, these were assumed to increase as policyholders got older ("How Insurance Companies Set Health Premiums" 2018) and be higher for women (Rimler 2016).

Retail price ranges for hearing aids were determined from three local Edmonton, Alberta, dispensaries, including two audiology clinics (Dispensers 1 and 2) and a bulk discount warehouse store (Dispenser 3). Similarly, retail price ranges for vision correction were estimated from three local dispensaries for a single complete pair of glasses with frames and lenses. We chose to obtain only treatment cost estimates for vision to compare with hearing aids, as optometry and audiology have similar assessments and both consistently provide corrective devices for sensory impairment. These treatment costs were compared with the insurance coverage amounts to estimate the coverage range and the expected out-of-pocket expenses, if any.

Results

Table 1 shows the minimum and maximum coverage corrected to a four-year term for services across all company plans considered along with the associated monthly plan costs. For hearing services, the coverage amounts ranged from CAD 300 to CAD 750 per four-year term, whereas vision services ranged from CAD 0 to CAD 900 per four-year term. For comparison, coverage for S-LP services ranged from CAD 0 to CAD 2,400 per four-year term, combined coverage for PT-R services ranged from CAD 1,400 to CAD 10,200 per four-year term and combined coverage for AM-R services ranged from CAD 0 to CAD 10,200 per four-year term. The monthly cost for plans considered in this study ranged from CAD 25.00 to CAD 225.42.

For a single hearing aid, cost estimates ranged from CAD 1,000 to CAD 6,000 (Table 2). The price point was dependent on the level of technology, included accessories and

services (e.g., length of warranty period). The lower end quote was each dispenser's most basic, least expensive model and service package, whereas the higher end quote was the newest, most expensive technology and comprehensive service package. The cost estimates for a complete pair of glasses ranged from CAD 139 to CAD 1,383 (Table 2). The frames and lenses were priced separately at each dispenser. Frames ranged in price from CAD 49 to CAD 610, whereas the lenses ranged in price from CAD 90 to CAD 780. The minimum costs for lenses were determined for basic single-vision plastic lenses with a mild prescription (-1.25) without coatings or protection. The maximum costs for lenses were determined for high-end progressive lenses with maximum anti-glare and other coatings.

TABLE 2. Cost for hearing care (i.e., single hearing aid) and vision care (i.e., single pair of glasses)

	Hearing aid cost (CAD)			Glasses cost (CAD)	
Dispenser	Min	Max	Dispenser	Min	Max
1	1,000	6,000	4	245	1,383
2	1,200	6,000	5	200	1,178
3	1,000	1,700	6	139	1,039
Average*	1,067	4,567	Average*	195	1,200
Median	1,000	6,000	Median	200	1,178

*Average rounded to the nearest dollar.

Discussion

In this study, we set out to describe, compare and evaluate health insurance plans for hearing care coverage within Alberta, Canada, to better understand the potential out-of-pocket expenses that would result if an individual chose to pursue treatment. Given that cost is the most commonly reported barrier to uptake and adherence to hearing services, a targeted analysis of this factor is an important step to identify and address the challenges faced by Canadians in need of a hearing device. Our findings are discussed in the context of coverage amounts and out-of-pocket expenses for comparable healthcare services to provide a more comprehensive description of the potential impact of cost barriers.

Coverage amounts

Not surprisingly, coverage amounts varied substantially across the various services we explored. For example, although the exact treatment estimates were not reported for SL-P, PT-R and AM-R services, the corrected four-year benefit coverage range was quite large (CAD 0–2,400, CAD 1,400–10,200 and CAD 0–10,200, respectively). With this large range, it therefore behooves the consumer to contrast and compare plan coverage and pricing for S-LP, PT-R, AM-R and vision care. In addition, the treatment costs for these therapies vary substantially, as these are largely service driven, whereas audiology and optometry primarily focus on dispensing medical devices for treatment. For example, hearing coverage had

a much more limited range (CAD 300–750). Although our investigation was not exhaustive, in general, our results indicate that consumers should expect fairly similar coverage amounts between companies and plan levels (e.g., basic vs. advanced) for hearing care.

A confounding factor in "equating" coverage amount was the differing coverage length across the health services. Although we attempted to overcome this factor by correcting coverage to a four-year benefit period, ultimately, the range of S-LP, PT-R and AM-R services may have been artificially inflated. That is, the company-specified benefit period for these categories is one year, meaning that unused coverage does not carry over. In addition, many companies put limits on reimbursement (e.g., CAD 25 per visit), making it difficult for consumers to maximize their coverage without incurring significant out-of-pocket expenses. However, even if we ignore the correction, most categories are still able to access similar coverage amounts each year (i.e., CAD 0–850), whereas hearing care is restricted to a minimum four-year benefit period. Such discrepancies in coverage amounts could potentially lead to perceived differences in importance, utilization and adherence of recommended services. Ultimately, future work that specifically addresses the impact of differing coverage amounts on perceptions and/or beliefs around these constructs is warranted.

A somewhat surprising finding of the current work was that less scientifically substantiated health treatment categories (e.g., homeopathy and other offerings within the AM-R classification) receive comparable or additional coverage to hearing services (NHMRC Statement on Homeopathy 2015; Zhang and Zehnder 2016). Individuals with hearing loss have scarce alternatives for treatment and, as already noted, untreated hearing loss has health implications that can be quite severe (Deal et al. 2017). Although a very small percentage of individuals may be eligible for corrective surgery or implantable devices, most will be required to purchase hearing devices to treat their disability for the remainder of their lifetime. Ultimately, longitudinal studies will need to be carried out to test the magnitude of costs that insurance companies (and/or individuals) incur as a result of untreated hearing loss and whether there are any cost-saving benefits associated with a reallocation of resources.

Out-of-pocket expenses

At first glance, there are no large differences between the range in coverage for hearing and vision care, with a difference in maximum coverage of CAD 150 (i.e., the maximum vision coverage available is CAD 900 from Company A, whereas the maximum hearing coverage available is CAD 750 from Company B). Hearing coverage is consistently lower (with the exception of Company B), but every company offers some financial relief. However, this comparison becomes considerably unbalanced when linked with treatment costs and subsequent out-of-pocket expenses. Treatment estimates for a single hearing aid can be magnitudes higher than vision correction, with the maximum cost for a pair of glasses approximating the price of a single basic-level hearing aid across all companies. This discrepancy increases further when we consider that most individuals who require treatment present with bilateral hearing loss and are recommended two hearing aids ("Hearing Loss of Canadians" 2016).

The cost range for a pair of hearing aids is then doubled to CAD 2,000–12,000 (Table 2). Proper treatment is important to achieve binaural hearing to improve listening ease and clarity, localize sound, avoid auditory deprivation and be able to listen in challenging environments such as background noise (Mencher and Davis 2006).

As was stated earlier, the coverage amounts for hearing care were for a four- or five-year benefit period across all companies. Aids typically need to be replaced every four to seven years, as hearing changes with age and electronics wear with use (O'Rourke 2014). With vision care, all but one company expressed coverage as a two-year benefit period. We will therefore assume that glasses are typically replaced every two years, which doubles the treatment cost estimate in Table 2 for a four-year benefit period. The cost range of two pairs of glasses is then corrected to CAD 278–2,766, which is still substantially less than the range (CAD 2,000–12,000) for two hearing aids.

Using the presented ranges along with hearing and vision care coverage amounts of CAD 300–750 and CAD 0–900, respectively, it is possible to obtain prescription eyewear with no out-of-pocket expenses (or 100% coverage) using individual insurance, as coverage amounts can meet or exceed treatment costs. However, an individual may still be required to pay up to CAD 2,766 out-of-pocket (or 0% coverage), as one company's basic plan includes no vision coverage. It was also observed that several companies had designated amounts (e.g., CAD 50) for eye examinations every benefit period, which was included in the insurance coverage amounts reported. No termed amounts for hearing assessments were noted for any company.

Out-of-pocket expenses for hearing aids cannot be avoided if an individual does not have access to any programs outside of their supplementary health insurance plan. These expected costs will range from CAD 250 to CAD 11,700 and will depend on the number of aids and chosen level of technology/service. It should be noted that most out-of-pocket expenses for medical devices and services are eligible to be used for non-refundable tax credits on income tax and benefit returns.

Increased insurance coverage, or decreased out-of-pocket expenses, is reported by 51% of non-hearing aid owners to be the most persuading factor that would facilitate adoption or uptake (Abrams and Kihm 2015). However, adoption rates in countries such as Norway, where hearing aids are fully subsidized (i.e., no out-of-pocket expenses), do not exceed 43% (Kirkwood 2015). Therefore, the contribution of cost as a barrier to hearing aid uptake requires further investigation, as its removal does not necessarily improve adoption rates. For example, stigma is also a highly reported factor that contributes to low uptake of hearing devices, whereby people report "not wanting to look old" and "not wanting people to think they are deficient" as reasons for not getting a hearing device (Wallhagen 2009). In keeping with the notion that uptake of hearing services is complex and multifactorial (Knudsen et al. 2010), it is likely that the removal of barriers needs to occur in conjunction with hearing education and knowledge regarding the pathway to hearing services, just to name a few.

Without proprietary information from the insurance companies, it is not possible to state how a consensus (i.e., comparable amounts and benefit periods) on hearing care

coverage was arrived at across the companies sampled. The amounts are far removed from current treatment cost estimates and do not seem to consider the increased incidence of bilateral hearing loss. Packer (2017) speculates that companies view hearing aids as an elective treatment, with hearing loss being a "likely risk" or an eventuality. In isolation, this high risk, with an aging population, combined with high treatment costs, may weigh heavy on the bottom line, making the inclusion or improvement of hearing care coverage in both public and private health insurance plans unlikely without mandated, lawful directives.

Further, there is some preliminary evidence that illustrates a link between hearing loss and possible risks for subsequent health issues (e.g., dementia; Deal et al. 2017; Livingston et al. 2017), which would likely have a more substantial impact on coverage costs for insurance companies (private and public) than the treatment of hearing impairments early on. These potential cascading effects need to be a consideration in future decisions about insurance coverage amount/length specific to hearing services. Such conversations should also be informed through future work that compares coverage across various sub-populations (e.g., veterans, disabled persons), provinces and countries. Although the targeted approach taken here on a large "cohesive" Canadian population (i.e., 18–64 years of age inclusive) allowed us to summarize the data into meaningful conclusions, there are many more factors to investigate that will undoubtedly complicate the matter. For example, although dementia is more common among individuals of age more than 65 years and the cohort studied here was 18–64 years of age inclusive, the hearing loss–dementia relationship is a product of several compounding factors that may be mitigated by adjustments to hearing coverage in this younger group. For example, with increased coverage may come increased hearing education, increased uptake of routine hearing assessments/screening, shifts in stigma around age and hearing loss as younger individuals seek hearing care, more preventative care with access to earlier hearing devices if needed/prescribed, etc. We hope that by concretely illustrating the disparities in hearing care coverage compared to both treatment costs and other paramedical services, as well as the out-of-pocket expenses incurred by those seeking treatment, we can stimulate discussion and advocacy for more hearing coverage.

Conclusion

This study evaluated individual or non-group insurance coverage for hearing care in Alberta, Canada, across eight companies for adults 18–64 years of age inclusive and provided a comparison with other common paramedical services. A considerable range and discrepancy were reported between hearing care and most paramedical services when values were corrected to equivalent benefit periods. In addition, the coverage amounts for hearing care were inconsistent with treatment costs, resulting in considerable out-of-pocket expenses for most consumers. Although the reasons for limited coverage for hearing services could only be speculated, as little information is available to the public, the potential implications of such cost-related barriers on public health are an important consideration as continued evidence is provided about the connection between hearing loss and increases in cognitive decline and dementia.

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What Changes Would Manitoba First Nations Like to See in the Primary Healthcare They Receive? A Qualitative Investigation

Quels changements les Premières Nations du Manitoba souhaiteraient apporter aux soins de santé primaires? Une enquête qualitative

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Abstract

Background: First Nations (FN) have unique perspectives and experiences of health and healthcare services, which are critical to the provision of effective community-based primary healthcare (CBPHC).

Objective: This paper shares FN perspectives on primary healthcare (PHC), taking geographical, cultural and historical realities into account, to elucidate opportunities to improve current healthcare services.

Methods: Semi-structured in-depth qualitative interviews were completed with 183 residents of 8 Manitoba FN communities. Grounded theory-guided data analysis was conducted.

Results: Improving PHC performance requires delivering timely and holistic healthcare that integrates traditional health knowledge, comprehensive CBPHC increasing services such as healthcare and medical transportation, healthy food as an important preventative measure and a culturally informed workforce backed by local leadership and promoting cultural respect.

Conclusion: The relationship between self-determination and health is a critical factor in the implementation of CBPHC. FN must be respected to decide healthcare priorities that reflect the needs and visions of each community.

Résumé

Contexte : Les Premières Nations (PN) ont un point de vue et une expérience uniques quant aux services de santé, dont la compréhension est essentielle pour offrir des soins de santé primaires communautaires (SSPC) efficaces.

Objectif : Cet article vise à mieux comprendre le point de vue des PN sur les soins de santé primaires (SSP) – en tenant compte des réalités géographiques, culturelles et historiques – afin de repérer les possibilités d'amélioration pour les services de santé actuellement en place.

Méthode : Des entrevues qualitatives semi-structurées approfondies ont été menées auprès de 183 résidents de communautés autochtones du Manitoba, suivi d'une analyse des données selon la théorie ancrée.

Résultats : L'amélioration du rendement des SSP demandera une prestation des services en temps opportun et une vision holistique des soins qui intègre les connaissances traditionnelles; plus de services complets pour les SSPC, comme les transports pour raison médicale; une saine alimentation comme mesure de prévention; et une main-d'œuvre sensibilisée au respect culturel avec l'aide d'intervenants locaux.

Conclusion : Le lien entre autodétermination et santé est un facteur clé de la mise en place des SSPC. Il est important de respecter les PN dans le choix de priorités en santé qui répondent aux besoins et à la vision de chacune des communautés.

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Development and Validation of a Brief Hospital-Based Ambulatory Patient Experience Survey (HAPES) Tool

Développement et validation d'un outil d'enquête sur l'expérience des patients ambulatoires en milieu hospitalier

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Abstract

Recognition of the value of the patient perspective on services has led healthcare organizations to measure patient care experiences. A brief, generic and psychometrically sound scale to measure patient experiences in ambulatory/outpatient settings in Canada would be useful and is currently lacking. The purpose of this study was to develop and validate an English-language hospital-based ambulatory patient experience survey tool in a Canadian context. Based on a review of more than 20 instruments measuring experiences predominately in non-acute care settings, we initially selected 27 items to be included in the questionnaire, addressing quality dimensions of access, communication, continuity and coordination, shared decision making, emotional support, trust/confidence, privacy, patient-reported impact and physical environment. The survey instrument was subsequently tested among 1,219 ambulatory patients, and its psychometric properties were assessed. A final questionnaire was produced with 14 items and two emerging subscales: Patient–Provider Communication and Overall Quality of Experience, as determined by a factor analysis. The items within the scale showed high construct validity. Reliability was also excellent for the instrument. The applicability of this tool in supporting quality improvement initiatives is discussed.

Résumé

La reconnaissance de la valeur du point de vue du patient sur les services a mené les organisations de santé à mesurer l'expérience des patients. Il serait utile d'avoir, au Canada, une brève échelle générique et psychométriquement solide pour mesurer l'expérience des patients en consultation ambulatoire ou externe. Le but de cette étude était de développer et de valider un outil d'enquête de langue anglaise sur l'expérience des patients ambulatoires en milieu hospitalier dans un contexte canadien. Sur la base d'une analyse de plus de 20 instruments mesurant l'expérience principalement dans des établissements de soins non actifs, nous avons sélectionné 27 éléments à inclure au questionnaire et qui portent sur les aspects qualitatifs de l'accessibilité, la communication, la continuité et la coordination, la prise de décision partagée, le soutien émotionnel, la confiance, la vie privée, l'impact signalé par le patient et l'environnement physique. L'instrument d'enquête a ensuite été testé auprès de 1 219 patients ambulatoires et ses propriétés psychométriques ont été évaluées. Cela a donné lieu à un questionnaire final comportant 14 items et deux sous-échelles émergentes : la communication patient-prestataire et la qualité globale de l'expérience, telles que déterminées par l'analyse factorielle. Les éléments de l'échelle présentent une validité de construit élevée. La fiabilité de l'instrument est également excellente. L'applicabilité de cet outil aux initiatives d'amélioration de la qualité est abordée dans l'article.

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